

Epic Resolute Professional Billing (PB) Fundamentals for Single Billing Office Practice Test (Sample)

Study Guide



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SAMPLE

Questions

- 1. What is the function of edit checks during claims processing?**
 - A. To validate patient eligibility**
 - B. To ensure compliance with billing rules before claim submission**
 - C. To finalize patient billing amounts**
 - D. To verify the accuracy of patient records**
- 2. What is the charge description master used for in Epic Resolute PB?**
 - A. A list of all medical staff**
 - B. A record of all patient interactions**
 - C. A comprehensive list of services and associated charges**
 - D. A guide for insurance reimbursement rates**
- 3. During the check-in process, what is typically confirmed?**
 - A. Insurance limits for the service provided**
 - B. Patient's scheduled appointment status**
 - C. Details regarding previous treatments**
 - D. Amount owed on future visits**
- 4. What does the term 'billed amount' exclude in healthcare billing?**
 - A. Discounts applied**
 - B. Insurance copays**
 - C. Cash payments**
 - D. All forms of reimbursements**
- 5. What does the 'charges' feature in Epic Resolute facilitate?**
 - A. Tracking and managing service costs**
 - B. Patient registration and insurance verification**
 - C. Inventory management for medical supplies**
 - D. Patient scheduling and follow-up**

- 6. Which of the following terms describes claims that need further attention due to lack of payment?**
- A. Outstanding claims**
 - B. Pending claims**
 - C. Processed claims**
 - D. Archived claims**
- 7. How does 'audit tracking' contribute to a billing office?**
- A. It reduces the number of claims submitted**
 - B. It provides a record of changes to patient accounts**
 - C. It simplifies employee performance reviews**
 - D. It enhances patient communication**
- 8. What does the guarantor status refer to in an account?**
- A. A flag for payment processing**
 - B. A flag for the entire guarantor account**
 - C. A status indicating bad debt**
 - D. A flag for dispute management**
- 9. Which task is involved in balancing cash at the front desk?**
- A. Ensuring all patient records are complete**
 - B. Reconciling the cash collected with the system records**
 - C. Scheduling future appointments**
 - D. Documenting patient satisfaction surveys**
- 10. How does 'claims scrubbing' improve the billing process?**
- A. By increasing the number of claims submitted**
 - B. By reducing clerical errors before submission**
 - C. By denying incorrect claims proactively**
 - D. By expediting electronic claim transmission**

Answers

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1. B
2. C
3. B
4. A
5. A
6. A
7. B
8. B
9. B
10. B

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Explanations

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1. What is the function of edit checks during claims processing?

- A. To validate patient eligibility**
- B. To ensure compliance with billing rules before claim submission**
- C. To finalize patient billing amounts**
- D. To verify the accuracy of patient records**

The function of edit checks during claims processing primarily revolves around ensuring compliance with billing rules before a claim is submitted. These edit checks serve as automated reviews that help identify potential errors in the claim data, including issues with codes, modifiers, and services billed. By catching these discrepancies early in the process, edit checks minimize the risk of claim denials and rejections from insurance payers, ultimately streamlining the billing workflow and improving revenue cycle management. In this context, though validating patient eligibility, finalizing patient billing amounts, and verifying the accuracy of patient records are all important aspects of the billing process, they are not the primary focus of edit checks. Edit checks specifically aim to enforce compliance with established guidelines and rules, which is crucial for a successful claims submission. This proactive measure ensures that claims submitted are more likely to be processed without delays or issues, enhancing the overall efficiency of the billing system.

2. What is the charge description master used for in Epic Resolute PB?

- A. A list of all medical staff**
- B. A record of all patient interactions**
- C. A comprehensive list of services and associated charges**
- D. A guide for insurance reimbursement rates**

The charge description master (CDM) in Epic Resolute Professional Billing plays a crucial role in the billing process by serving as a comprehensive list of services and associated charges. This master list outlines all the services that can be billed to patients and insurance providers, detailing each service's description, cost, and billing codes. This information is essential for creating accurate and timely billing statements and ensuring that healthcare providers are reimbursed appropriately for the services rendered. The CDM is integral in maintaining consistency and accuracy in billing processes, helping to reduce errors and streamline the revenue cycle. By having a well-maintained CDM, billing offices can ensure compliance with regulations and standards in healthcare billing, while also providing transparency to patients regarding the services they receive and the costs associated with them.

3. During the check-in process, what is typically confirmed?

- A. Insurance limits for the service provided**
- B. Patient's scheduled appointment status**
- C. Details regarding previous treatments**
- D. Amount owed on future visits**

Confirming the patient's scheduled appointment status during the check-in process is essential for ensuring that the practice is prepared for the patient's visit. This involves verifying the date, time, and nature of the appointment. Ensuring that the patient has arrived as scheduled allows staff to manage their time effectively, allocate resources appropriately, and maintain an organized flow in the clinic. Additionally, confirming the appointment status can help in identifying any potential issues early, such as patients who may have missed their scheduled time or require rescheduling. While other options like insurance limits, previous treatments, and amounts owed on future visits are relevant aspects of patient billing and care, the primary focus at check-in is accurately confirming that the patient is present and ready for their scheduled appointment. This provides the foundation for any subsequent interactions related to treatment and billing.

4. What does the term 'billed amount' exclude in healthcare billing?

- A. Discounts applied**
- B. Insurance copays**
- C. Cash payments**
- D. All forms of reimbursements**

In healthcare billing, the 'billed amount' refers to the total amount that a healthcare provider invoices for services rendered before any deductions or adjustments are applied. This includes the full value of the services provided, but does not account for any reductions to the amount owed due to discounts, adjustments, or other financial considerations that may be applied later. When considering discounts specifically, they are often applied after the initial billed amount is calculated. Therefore, the billed amount excludes any discounts that a provider might offer, which would reduce the final amount that the patient or payer is ultimately responsible for. It's important to discern between the billed amount and other financial elements, such as insurance copays, cash payments, and reimbursements, all of which are accounted for in the payment process but do not impact the initial billed amount itself. Understanding this distinction is critical when analyzing billing statements and ensuring accurate financial reporting in a healthcare setting.

5. What does the 'charges' feature in Epic Resolute facilitate?

- A. Tracking and managing service costs**
- B. Patient registration and insurance verification**
- C. Inventory management for medical supplies**
- D. Patient scheduling and follow-up**

The 'charges' feature in Epic Resolute is primarily designed to track and manage service costs effectively. It allows billing staff to input, monitor, and analyze the charges associated with patient care. This functionality is crucial for ensuring that all services rendered to patients are accurately documented and billed, which in turn promotes proper revenue cycle management. By facilitating detailed tracking of charges, the feature helps in maintaining billing accuracy, reducing discrepancies, and ensuring that the medical practice receives appropriate reimbursement for the services provided. This capability is essential for financial health and operational efficiency within a healthcare setting. The other choices, while important aspects of a healthcare administration system, do not pertain specifically to the charging process. For example, patient registration and insurance verification relate more to the front-end processes of patient intake, while inventory management deals with supplies and equipment rather than service costs. Patient scheduling and follow-up focus on appointment management rather than financial tracking. Therefore, it is the 'charges' feature that plays a pivotal role in the financial component of patient care management.

6. Which of the following terms describes claims that need further attention due to lack of payment?

- A. Outstanding claims**
- B. Pending claims**
- C. Processed claims**
- D. Archived claims**

The term that describes claims needing further attention due to a lack of payment is outstanding claims. Outstanding claims refer to those that have been submitted but not yet paid by the insurer or payer, often requiring follow-up or further investigation to understand the reasons for non-payment. Pending claims, while related, typically refer to claims that are awaiting processing or a decision by the payer rather than those that have been processed and are still outstanding due to lack of payment. Processed claims indicate that the claims have completed the review process and a determination has been made, whether payment is pending or not. Archived claims refer to those that have been stored away and are not actively being addressed, usually as a result of aging and being no longer relevant to immediate billing practices. Therefore, outstanding claims is the most accurate term for identifying claims that require further attention because of issues with payment.

7. How does 'audit tracking' contribute to a billing office?

- A. It reduces the number of claims submitted**
- B. It provides a record of changes to patient accounts**
- C. It simplifies employee performance reviews**
- D. It enhances patient communication**

The role of audit tracking within a billing office is essential in maintaining accurate documentation and oversight of patient accounts. By providing a comprehensive record of changes made to patient accounts, audit tracking ensures transparency and accountability in billing practices. This documentation allows billing personnel to trace back modifications, understand the reasons behind them, and maintain compliance with regulatory standards. Having a clear audit trail is invaluable for resolving discrepancies, answering patient inquiries about their bills, and preparing for potential audits from insurance companies or regulatory bodies. It also supports internal reviews, enabling billing staff to assess the accuracy of submissions and correct any errors before they become larger issues. Furthermore, audit tracking can help identify trends or recurring problems that may need addressing, ultimately improving the billing process and enhancing overall office efficiency. This thorough documentation reinforces trust with both patients and payers by demonstrating diligence in managing financial transactions.

8. What does the guarantor status refer to in an account?

- A. A flag for payment processing**
- B. A flag for the entire guarantor account**
- C. A status indicating bad debt**
- D. A flag for dispute management**

The guarantor status pertains to the overall management of a guarantor account, which is crucial for understanding the financial responsibility of patients and their involvement in billing processes. The guarantor is typically the individual or entity responsible for paying the medical bills resulting from services rendered. When this status is classified as a flag for the entire guarantor account, it allows the billing office to effectively track and manage billing and payment processes associated with that guarantor. This comprehensive view ensures that all accounts tied to the guarantor are linked and appropriately handled concerning billing practices, payment collections, and any follow-up actions needed. Additionally, having a clear designation of the guarantor status helps streamline operations, as it allows billing offices to quickly reference who is ultimately responsible for payments and assists in maintaining accurate accounts.

9. Which task is involved in balancing cash at the front desk?

- A. Ensuring all patient records are complete**
- B. Reconciling the cash collected with the system records**
- C. Scheduling future appointments**
- D. Documenting patient satisfaction surveys**

Balancing cash at the front desk primarily involves reconciling the cash collected with the system records. This process ensures that the amount of cash on hand matches the amount that has been recorded in the practice's billing system. It is critical for maintaining accurate financial records and identifying any discrepancies that may need to be addressed. This task helps to ensure financial integrity and accountability, as well as aids in identifying any potential issues such as underpayment or overpayment by patients. The other tasks listed, while important for overall practice management, do not directly pertain to the cash balancing process. Ensuring patient records are complete and scheduling future appointments focus on patient administrative tasks, while documenting patient satisfaction surveys targets quality assessment rather than financial reconciliation.

10. How does 'claims scrubbing' improve the billing process?

- A. By increasing the number of claims submitted**
- B. By reducing clerical errors before submission**
- C. By denying incorrect claims proactively**
- D. By expediting electronic claim transmission**

Claims scrubbing plays a crucial role in the billing process by focusing on ensuring the accuracy and completeness of claims before they are submitted. The primary objective of claims scrubbing is to identify and correct any clerical errors, inconsistencies, or missing information that could lead to claim denials or delays in payment. This process typically involves the use of specialized software or a set of guidelines that helps billing professionals review each claim meticulously. By addressing issues such as incorrect patient data, invalid procedure codes, or mismatched diagnosis codes, claims scrubbing enhances the quality of the claims being submitted. When claims are accurate right from the outset, it reduces the likelihood of denied claims and subsequently minimizes time spent on appeals or resubmissions, ultimately streamlining the billing workflow. Moreover, a higher accuracy rate in submitted claims not only improves revenue cycle efficiency but also fosters better relationships with payers, as they appreciate receiving well-prepared claims that are less likely to be contested. Overall, the scrubbing process contributes significantly to a more efficient and effective billing system, leading to improved financial outcomes for healthcare providers.